Patient Registration Form- Yearly update 2024

(Please complete in its entirety to ensure proper billing and insurance payment)

Portland Asthma Allergy 2024

1. Please bring insurance cards, photo ID and all new patient paperwork filled out in its entirety.

2. Bring all medication or a complete list of your current medications, including over the counter medications and supplements.

3. Please arrive 30 minutes before your appointment time and allow up to 1.5 hours for your first appointment.

4. Please call 48 hours in advance if you need to cancel or reschedule to avoid a $50.00 no show fee and potential cancellation of your referral.

5. If you have any symptoms of Covid or another respiratory illness, please call the clinic and speak to a member of the nursing staff prior to coming in for your appointment.

6. Cash pay and co-pay are expected at the time of service.

7. Young adults under the age of 18 are required to bring a parent or legal guardian.

8. Failure to comply with any of the requirements above will result in cancellation of your appointment.

Southeast: 8740 SE Sunnybrook Blvd # 300, Clackamas 97015 PH 971-358-5600
Southwest: 9370 SW Greenburg Rd # 311, Portland 97223 PH 503-245-8060
Northeast: 2150 NE Division Street # 202, Gresham, 97030 PH: 971-358-5800
Fax Number for all locations: 971-358-5801

All fields need to be filled out even if we have a copy of your insurance card:

***Legal Name: _____Preferred Name:_____**

*Legal Sex: M or F(circle one) DOB:_____Pronouns:_____

Address:_____

Occupation:_____ Social Security number : _____

Phone #_____Email:_____

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(signature on this form gives us permission to text or email based on clinic needs, and not used for marketing purposes)

Responsible Party if under 18:_____

Responsible Party Employer: _____ Phone#_____

DOB: _____Relationship_____

(Please provide even if you are giving us your insurance card)

Primary

Insurance:_____ID#_____Grp:#_____

Policy Holder's Name: _____DOB:_____

Secondary Insurance (if applicable)

Insurance: _:_____ID#_____Grp#_____

Policy Holder Name: _____DOB:_____

Preferred Pharmacy:_____Location/Ph #_____

Emergency Contact:_____Ph#_____

Referring Provider/PCP:_____

Releasing information to other parties including insurance companies and adults over 18 that are still on parent's insurance:

I (Signature)_____authorize Portland Allergy & Asthma to share and/or release my **medical/billing information** to the following individuals: I understand that I can cancel this consent at any time (in writing to Portland Allergy & Asthma) but that canceling it will not affect any information that has already been released. **PLEASE PRINT ALL NAMES LISTED BELOW. PLEASE DO NOT LIST PHYSICIANS. (If no name is listed below, this means we can only discuss information with patients only.)**

Name:_____Ph#_____Relationship:_____

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(Please complete in its entirety to ensure proper billing and insurance payment)

Name:_____Ph#_____Relationship:_____

Or, I decline permission to discuss my medical/financial information with others outside of insurance companies or medical providers._____(Initial)

Clinic and Financial Policies:

1. I understand it is my responsibility to pay my copay at every visit, or I may incur a $20.00 billing charge. _____(**initial**)

2. I understand that there is a **$50.00** no-show fee incurred for any office visit appointments not canceled with more than 24 hours' notice, and a **$100.00** no show fee for any *procedure* not canceled with more than 24 hours' notice. Failure to pay no show fee and 2 or more no shows will result in discharge from the practice._____(**initial**)

3. I understand that although Portland Allergy and Asthma will provide me with good faith estimates, when requested by the patient prior to the appointment, it is my responsibility to coordinate benefits with my insurance company for Allergy/Asthma services covered under my plan, and primary care physician if a referral is needed prior to being seen. It is my responsibility to contact my insurance to determine if office visits, testing, serum, injections, and treatments are covered under my plan and how they are covered (if subject to my deductible, copay, and coinsurance) and to verify if my insurance/plan is network with Portland Allergy and Asthma before any services are done. ._____(**initial**)

4. I understand that if my account falls into a delinquent status, I will be unable to make further appointments, fill/refill prescriptions or get allergy/venom shots until my account is brought current. _____(**initial**)

5. **I understand that although Portland Allergy and Asthma will do the best to work with me on my financial matters, if my account is delinquent for over 120 days**, I will be sent to collections and understand that the collection agency will have additional fees and may include a judgment over and above my balance. At that point I will be discharged from the practice._____(**initial**)

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6. I understand that Portland Allergy and Asthma charges a **$50.00 NSF** fee for any payments returned from the bank, and that I will then need to pay Cash or Credit/Debit Card moving forward. Should I not pay this fee, I will be discharged from the practice._____(**initial**)

7. Oral immunotherapy patients, ***there is a non-refundable fee of $25.00**** that will be charged at each of your appointments that you receive take home doses. This fee includes time involved in creating your customized daily doses as well as the food and medical supplies involved during the desensitization process while the patient is on food solution.

*Supply charges are not covered by insurance and must be paid on or before your appointment.

High Deductible Plans

PDX- Allergy & Asthma recognizes the challenging times we are all facing. We are available to speak with you and can assist you with making arrangements to pay your bill. Please reach out to us if you have any questions or concerns. A deductible deposit will be requested for services if your remaining deductible is over $1000.00. You will be required to pay a 20% Deposit before the services can be done. We will collect 20% of the total services cost or 20% of remaining deductible balance; whichever is lower for the Deductible Deposit amount. If payment arrangements are needed, we ask that they be set up within 15 days from receiving your bill and prior to statement due date; whenever the bill cannot be paid in full at the time of the first billing statement.

When *Payment Plans* are set up, they are set up for the patient balance at that time. Any future visits will not be included in the monthly payment plan. You will be responsible for paying for all future visits in full, in addition to your monthly payment plan.

If, at any time, any of your future visits are over $300.00, please contact the Billing Department to see if we can combine it with your existing payment plan. Anytime there are new balances added to your existing payment plan, we will have to increase the

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monthly payment plan amount. The account guarantor is responsible for making appropriate financial arrangements with the Billing Department.

If payment arrangements are needed: Please call our Billing Department at 971-358-5800 Option 2 to set up a payment plan.

Online payments can be made at https://www.portland-allergy.com/

Agreement/Authorization

My signature below indicates that I accept and understand the above policies and give Portland Allergy and Asthma permission to speak with and bill my insurance company on my behalf, including the release of needed medical information. I also hereby authorize payment of medical benefits to Portland Allergy and Asthma when an assigned claim is filed.

Patient/Responsible Party

Signature:_____

Date signed:_____

- I understand I can revoke this authorization at any time by written notice of my decision to:

- Portland Allergy and Asthma, ATTN: Angie M. 8740 SE Sunnybrook Blvd Suite 300 Clackamas, Or 97015.

- If I withdraw this authorization, Portland Allergy and Asthma may not afterwards disclose my information for the purpose listed above. However, I cannot retroactively revoke authorization if disclosure has already occurred.Should I revoke this authorization in regards to my insurance company, I understand that I will be responsible for 100% of my bill due to the practice of not being able to bill the insurance company without authorization.

Enter Name

Enter Address

Enter City/State/Zip

Today's Date: _____

Patient's Name: _____

Childhood Asthma Control Test for children 4 to 11 years.

This test will provide a score that may help the doctor determine if your child's asthma treatment plan is working or if it might be time for a change.

How to take the Childhood Asthma Control Test

Step 1 Let your child respond to **the first four questions (1 to 4)**. If your child needs help reading or understanding the question, you may help, but let your child select the response. Complete the remaining **three questions (5 to 7)** on your own and without letting your child's response influence your answers. There are no right or wrong answers.

Step 2 Write the number of each answer in the score box provided.

Step 3 Add up each score box for the total.

Step 4 Take the test to the doctor to talk about your child's total score.

19 or less If your child's score is 19 or less, it may be a sign that your child's asthma is not controlled as well as it could be. Bring this test to the doctor to talk about the results.

Have your child complete these questions.

1. How is your asthma today?

0 **Very bad**

1 **Bad**

2 **Good**

3 **Very good**

SCORE ☐

2. How much of a problem is your asthma when you run, exercise or play sports?

0 **It's a big problem, I can't do what I want to do.**

1 **It's a problem and I don't like it.**

2 **It's a little problem but it's okay.**

3 **It's not a problem.**

☐

3. Do you cough because of your asthma?

0 **Yes, all of the time.**

1 **Yes, most of the time.**

2 **Yes, some of the time.**

3 **No, none of the time.**

☐

4. Do you wake up during the night because of your asthma?

0 **Yes, all of the time.**

1 **Yes, most of the time.**

2 **Yes, some of the time.**

3 **No, none of the time.**

☐

Please complete the following questions on your own.

5. During the last 4 weeks, how many days did your child have any daytime asthma symptoms?

5	4	3	2	1	0
Not at all	1-3 days	4-10 days	11-18 days	19-24 days	Everyday

☐

6. During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

5	4	3	2	1	0
Not at all	1-3 days	4-10 days	11-18 days	19-24 days	Everyday

☐

7. During the last 4 weeks, how many days did your child wake up during the night because of asthma?

5	4	3	2	1	0
Not at all	1-3 days	4-10 days	11-18 days	19-24 days	Everyday

☐

TOTAL ☐

Health History Portland Allergy & Asthma **Questionnaire**

Patient Name:

_____ Age: _____ Date of Birth: _____ Sex: M__F__

Primary Care Provider: _____

Preferred Pharmacy/Address: _____

Pharmacy Phone #: _____ Fax #: _____

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY. Base your answers on your own observations and not on what others have told you or what you may have assumed on the basis of previous allergy tests. Please complete this form before seeing the allergist as the information will organize your thinking and help us to understand your problem.

What are the problems that bring you to an allergist?

_____

_____

Please indicate the symptoms you experience:

EARS	Yes	No
Itching	( )	( )
Fullness	( )	( )
Popping	( )	( )
Tubes placed	( )	( )
Hard of hearing	( )	( )
Frequent infections	( )	( )
# ear infections/year _____		

THROAT	Yes	No
Soreness	( )	( )
Post-Nasal Drip	( )	( )
Itching of Palate	( )	( )
Recurrent Strep infections	( )	( )
Hoarseness	( )	( )
Tonsils	( )	( )
Adenoids removed	( )	( )

NOSE/SINUS	Yes	No
Repeated Sneezing	( )	( )
Watery discharge	( )	( )
Stuffy nose	( )	( )
Itching	( )	( )
Nasal trauma	( )	( )
Bloody nose	( )	( )
Poor sense of smell	( )	( )
Mouth breathing	( )	( )
Bad breath	( )	( )
Snoring	( )	( )

EYES	Yes	No
Contact Lenses	( )	( )
Itching	( )	( )
Burning	( )	( )
Watering	( )	( )
Swelling	( )	( )
Redness	( )	( )
Discharge	( )	( )
Glaucoma	( )	( )
Cataract	( )	( )

How many times a year are you treated with antibiotics for nasal/sinus infections? _____

For how long each time? _____

Date of last sinus x-rays? _____ Date of last CT scan of sinuses? _____

Date of any sinus surgery _____

CHEST	Yes	No
Cough	( )	( )
Wheezing	( )	( )
Sputum (phlegm)	( )	( )
Shortness of breath	( )	( )
at rest	( )	( )
with exercising	( )	( )
Coughed up blood	( )	( )
History of bronchitis	( )	( )
History of pneumonia	( )	( )
Positive TB skin test	( )	( )

Date of last chest x-ray: _____

Result: _____

SKIN	Yes	No
Eczema	( )	( )
Hives	( )	( )
Swelling	( )	( )
Infections (boils, impetigo)	( )	( )

Names(s) of skin soap(s)/shampoo(s)/moisturizers used? _____

_____

_____

Do you have problems wearing LATEX GLOVES

or using latex products? (specify) _____
Date of last pulmonary function studies: _____
Result:_____

ASTHMA HISTORY

Have you ever been intubated, placed in intensive care, or on a respirator for asthma? _____
# of hospitalizations for asthma: _____ # of emergency room visits for asthma in the last year: _____
Number of courses of oral steroids (Prednisone/Medrol) taken for asthma in the past year: _____
Do you have a peak flow monitor? _____ What is your best peak flow reading: _____
# of times per month awakened with asthma (chest tight/wheeze/cough/short of breath) _____
# of times per week you need to use inhaler for acute asthma (beyond scheduled doses) _____
Is your asthma worse at school or work? _____

SEASONAL INCIDENCE

Please indicate your age when symptoms first appeared and check off the months in which the symptoms occur.

	Age of onset:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Wheezing	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Coughing	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Nasal	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Eye	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Hives	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Eczema	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )
Other	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )	( )

Are symptoms worse after exposure to:

( ) Raking leaves	( ) Humidity/heat	( ) Cigarette smoke	( ) Medications
( ) Lawn mowing	( ) Cold air	( ) Perfumes	
( ) Hay/compost	( ) Air conditioning	( ) Strong odors	
( ) Damp basement	( ) Weather changes	( ) Newsprint	
( ) Animals/Pets	( ) Smog (exhaust fumes)	( ) Foods	

ENVIRONMENT

How long have you lived in the Pacific Northwest? _____
Prior states(s)? _____
Type of home _____ How old is home? _____ How long lived there? _____
Location of home ( ) Country ( ) Suburb ( ) City
Basement ( ) yes ( ) no What is the basement used for? _____
Is basement ( ) dry ( ) damp
Does anyone at home smoke? ( ) yes ( ) no
Who?_____ How much?_____

ANIMALS:

Do you have any pets? ( ) yes ( ) no
If yes, please list: _____
How long have the pets been with you? _____
Does the animal have full use of the house? ( ) yes ( ) no
Does the animal sleep on the patient's bed? ( ) yes ( ) no
Does animal exposure make symptoms worse? ( ) yes ( ) no

PATIENT'S BEDROOM:

Mattress
Age: _____ years
Type:
Innerspring cotton ( )
Foam ( )
Other _____

Pillow(s)
Age: _____ years
Type:
Feather ( )
Foam rubber ( )
Synthetic ( )
Buckwheat ( )

INSECT ALLERGY

After a bee sting do you have problems with:

	Yes	No		Yes	No
Local swelling	( )	( )	Hives	( )	( )

Tongue/Lip swelling	( )	( )	Swelling	( )	( )
Scattered hives	( )	( )	Shortness of breath	( )	( )

Have you ever been treated in an Emergency Room for an insect sting? _____ Date: _____

FOOD ALLERGIES/SENSITIVITIES: Do you have problems with any foods? If yes, describe the problem. For instance: swelling or itching of tongue, lips, or mouth? Rashes or hives? Immediate or delayed vomiting or diarrhea?

Eggs	_____	Fish	_____
Wheat	_____	Melon	_____
Milk	_____	Bananas	_____
Cheese	_____	Walnuts	_____
Shellfish	_____	Peanuts	_____
Tomatoes	_____	Soy	_____
Others	_____		

DRUG ALLERGIES/SENSITIVITIES: Please list all medications to which you have had an adverse reaction and describe that reaction.

Medication Name	Approximate date and description of reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT HEALTH HISTORY: Have you had any of the following?

	Yes	No		Yes	No
High blood pressure	( )	( )	Diabetes	( )	( )
Heart disease or arrhythmia	( )	( )	Thyroid disease	( )	( )
Blood transfusion	( )	( )	Liver disease	( )	( )
Uncontrolled bleeding	( )	( )	Kidney disease	( )	( )
Dental problems	( )	( )	Arthritis	( )	( )
Cancer	( )	( )	Heartburn	( )	( )
Childhood Chicken Pox	( )	( )	Chronic diarrhea	( )	( )

Other ongoing medical problems? Please list: _____

_____

_____

Surgeries: Please list procedure:	Date:
_____	_____
_____	_____
_____	_____

Hospitalizations: Please list reason:	Date:
_____	_____
_____	_____
_____	_____

MEDICATIONS: Please list **ALL** medications that you are currently taking, dosage, frequency, and for what condition(s).

Medication name/dosage	*Frequency*	*For what condition(s)*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____
_____ _____ _____

IMMUNIZATIONS:

	Yes	No	Date(s)
Childhood series	( )	( )	_____
Hepatitis B	( )	( )	_____
Tetanus	( )	( )	_____
Pneumovax	( )	( )	_____
Chicken Pox Vaccine	( )	( )	_____

FAMILY HEALTH HISTORY

	Mother	Father	Brother(s)	Sister(s)	Children	Grandparent(s)		
Hay Fever/Allergies:	( )	( )	( )	( )	( )	( )	( )	( )
Sinus Trouble:	( )	( )	( )	( )	( )	( )	( )	( )
Asthma:	( )	( )	( )	( )	( )	( )	( )	( )
Frequent Bronchitis:	( )	( )	( )	( )	( )	( )	( )	( )
Eczema:	( )	( )	( )	( )	( )	( )	( )	( )
Hives:	( )	( )	( )	( )	( )	( )	( )	( )
Migraine Headaches:	( )	( )	( )	( )	( )	( )	( )	( )
Thyroid Disease:	( )	( )	( )	( )	( )	( )	( )	( )
Food Allergies:	( )	( )	( )	( )	( )	( )	( )	( )
Other: _____	( )	( )	( )	( )	( )	( )	( )	( )

Any other chronic illnesses, (i.e., heart, lung, kidney) or diseases? _____

SOCIAL HISTORY

( ) Married ( ) Single ( ) Divorced ( ) Widowed
Occupation of patient: _____
Briefly describe workplace/school environment:
._____
_____
Number of days work/school missed in last year: _____
Does the patient consume alcoholic beverages? ( ) yes ( ) no
If yes, type and frequency?_____
Does the patient smoke? ( ) Current ( ) Former ( ) Never
If yes, how many packs/day?_____

Please list your hobbies and/or spare time activities:

THIS SECTION TO BE COMPLETED BY PHYSICIAN

R.O.S._____
_____

Eyes	_____	Lungs	_____
Ears	_____	Heart	_____
Nose	_____	Abdomen	_____
Sinus	_____	Extremities	_____
Oropharynx	_____	Skin	_____
		Neck	_____

POEM
Patient-Oriented Eczema Measure

University of Nottingham
UK | CHINA | MALAYSIA

POEM for self-completion and/or proxy completion

Patient Details: _____
_____
_____
_____

Date: _____

Please circle one response for each of the seven questions below about your/your child's eczema. If your child is old enough to understand the questions then please fill in the questionnaire together. Please leave blank any questions you feel unable to answer.

1. Over the last week, on how many days has your/your child's skin been itchy because of the eczema?

No days | 1-2 days | 3-4 days | 5-6 days | Every day

2. Over the last week, on how many nights has your/your child's sleep been disturbed because of the eczema?

No days | 1-2 days | 3-4 days | 5-6 days | Every day

3. Over the last week, on how many days has your/your child's skin been bleeding because of the eczema?

No days | 1-2 days | 3-4 days | 5-6 days | Every day

4. Over the last week, on how many days has your/your child's skin been weeping or oozing clear fluid because of the eczema?

No days | 1-2 days | 3-4 days | 5-6 days | Every day

5. Over the last week, on how many days has your/your child's skin been cracked because of the eczema?

No days | 1-2 days | 3-4 days | 5-6 days | Every day

6. Over the last week, on how many days has your /your child's skin been flaking off because of the eczema?

No days | 1-2 days | 3-4 days | 5-6 days | Every day

7. Over the last week, on how many days has your/your child's skin felt dry or rough because of the eczema?

No days | 1-2 days | 3-4 days | 5-6 days | Every day

Total POEM Score (Maximum 28): _____

POEM
Patient-Oriented Eczema Measure

University of Nottingham
UK | CHINA | MALAYSIA

POEM for self-completion and/or proxy completion

How is the scoring done?

Each of the seven questions carries equal weight and is scored from 0 to 4 as follows:

No days	= 0
1-2 days	= 1
3-4 days	= 2
5-6 days	= 3
Every day	= 4

Note:

• If one question is left unanswered this is scored 0 and the scores are summed and expressed as usual out of a maximum of 28

• If two or more questions are left unanswered the questionnaire is not scored

• If two or more response options are selected, the response option with the highest score should be recorded

What does a poem score mean?

To help patients and clinicians to understand their POEM scores, the following bandings have been established (see references below):

• 0 to 2	= Clear or almost clear
• 3 to 7	= Mild eczema
• 8 to 16	= Moderate eczema
• 17 to 24	= Severe eczema
• 25 to 28	= Very severe eczema

Do I need permission to use the scale?

The POEM scale is protected by copyright. Commercial users must pay a per patient fee – details are available at https://licensing.micragateway.org/product/poem---patient-orientated-eczema-measure

POEM remains freely available for non-commercial use and can be downloaded from: www.nottingham.ac.uk/dermatology
We do however ask that you register your use of the POEM by e-mailing cebd@nottingham.ac.uk with details of how you would like to use the scale, and which countries the scale will be used in.

References

Charman CR, Venn AJ, Williams HC. The Patient-Oriented Eczema Measure: Development and Initial Validation of a New Tool for Measuring Atopic Eczema Severity From the Patients' Perspective.
Arch Dermatol. 2004;140:1513-1519

Charman CR, Venn AJ, Ravenscroft JC, Williams HC. Translating Patient-Oriented Eczema Measure (POEM) scores into clinical practice by suggesting severity strata derived using anchor-based methods.
Br J Dermatol. Dec 2013; 169(6): 1326–1332.

RHINITIS CONTROL ASSESSMENT TEST (RCAT)

PATIENT NAME: _____

DATE COMPLETED: _____

PLEASE CHECK THE CATEGORY THAT BEST ANSWERS THE QUESTION.
Write the score for each item in the column to the right.

1. During the past WEEK, how often did you have nasal congestion?

Never	Rarely	Sometimes	Often	Extremely Often	SCORE
5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	

2. During the past WEEK, how often did you sneeze?

Never	Rarely	Sometimes	Often	Extremely Often	SCORE
5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	

3. During the past WEEK, how often did you have watery eyes?

Never	Rarely	Sometimes	Often	Extremely Often	SCORE
5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	

4. During the past WEEK, to what extent did your nasal or other allergy symptoms interfere with your sleep?

Never	Rarely	Sometimes	Often	Extremely Often	SCORE
5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	

5. During the past WEEK, how often did you AVOID any activity (for example, gardening, exercising, visiting a house with a dog or cat) because of your nasal or other allergy symptoms?

Never	Rarely	Sometimes	Often	Extremely Often	SCORE
5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	
				TOTAL SCORE	

The higher the score, the better controlled you are with your nose and eye symptoms.

A score that is **lower** than **21** suggest that you are not well-controlled.

Portland
Allergy & Asthma

REVIEW OF SYSTEMS

Patient Name:_____ DOB: _____ Date:_____

For recent symptoms *related to your visit today*. Please review and check all that apply.

General
_____Fever
_____Weight loss
_____Weight Gain
_____ Fatigue
_____ Night Sweats
_____ Frequent Infections
_____ Headaches

Skin
_____Rash
_____ Hives
_____ Itching
_____ Hair loss
_____ Dry Skin
_____ Eczema

Allergies
_____ Seasonal
_____ Year long
_____ Food Allergies

Ears/ Nose/ Throat
_____ Nasal Congestion
_____ Sore Throat
_____ Postnasal Drip
_____ Runny Nose
_____ Ear Pain

Eyes
_____Redness
_____ Pain
_____ Itching
_____ Watering
_____ Blurred Vision

Respiratory
_____ Wheezing
_____ Coughing
_____Shortness of Breath
_____Chest Tightness
_____Sputum Production

Cardiovascular

_____ High Blood Pressure
Medication name_____
_____ Dizziness
_____ Chest Pain
_____ Swelling in feet/legs
_____ Heart Palpitations

GI (Food Allergy Visit Only)
_____ Abdominal Pain
_____ Nausea
_____ Vomiting
_____ Diarrhea
_____ Constipation
_____ Heartburn
_____ Bloating

Cancer
_____ History of Cancer
Type_____

Hematologic (Immunology Visit Only)

_____Easy Bleeding
_____ Easy Bruising
_____ Anemia
_____ Abnormal blood tests
_____ Blood Clots

Other
_____
_____
_____
_____